CHAPTER II

PROVIDER PARTICIPATION REQUIREMENTS

CHAPTER II
TABLE OF CONTENTS

CHAPTER II
PROVIDER PARTICIPATION REQUIREMENTS

PARTICIPATING PROVIDER

A participating provider is a mental health clinic which has a current, signed participation agreement with the Department of Medical Assistance Services (DMAS).

PROVIDER ENROLLMENT

Any provider of services must be enrolled in the Medicaid Program prior to billing for any services provided to Medicaid recipients. Providers must sign the appropriate Participation Agreement and return it to the Provider Enrollment and Certification Unit of the FIRST HEALTH Services Corporation; an original signature of the individual provider is required. An agreement for a hospital or other agency or institution must be signed by the authorized agent of the provider. The Department of Medical Assistance Services must receive prior written notification of the identity of any designated authorized representative and the fact that a principal-agent relationship exists. (See "Exhibits" at the end of this chapter for a sample of the mental health clinic participation agreement.)

Upon receipt of the above information, a provider number is assigned to each approved provider. This number must be used on all claims and correspondence submitted to the Medicaid Program.

This manual contains instructions for billing and specific details concerning the Medicaid Program. Providers must comply with all sections of this manual to maintain continuous participation in the Medicaid Program.

SPECIFIC PROVIDER REQUIREMENTS

Federal law requires that each clinic be physician-directed.

"As stipulated by section 1905 (a)(9) of title XIX of the Social Security Act, this requirement does not mean that the physician must necessarily be an employee of the clinic, or be utilized on a full time basis or be present in the facility during all the hours that services are provided. However, each patient's care must be under the supervision of a physician directly affiliated with the clinic. To meet this requirement, a physician must see the patient at least once, prescribe the type of care provided, and, if the services are not limited by the prescription, periodically review the need for continued care. Although the physician does not have to be on the premises when his/her patient is receiving covered services, the physician must assume professional responsibility for the services provided and assure that the services are medically appropriate. Thus, physicians who are affiliated with the clinic, must spend as much time in the facility as is necessary to assure that patients are getting services in a safe and efficient manner in accordance with accepted standards of medical practice. For a physician to be affiliated with a clinic there

must be a contractual agreement or some other type of formal arrangement between the physician and the facility by which the physician is obligated to supervise the care provided to the clinic's patients. Some clinics will require more physician involvement than one person can provide. The size of the clinic and the type of services it provides should be used to determine the number of physicians that must be affiliated with a clinic to meet the physician direction requirement."

The requirement for physician supervision of all patient care in the clinic is a condition of participation in Medicaid as a mental health clinic. The patient care protocols for treatment of Medicaid recipients must reflect the role of the physician, and the patient's medical records must document that the physician has ordered the plan of care and is periodically reviewing the need for continued care. This requirement must be met for all clinic services billed to Medicaid by any employee of the mental health clinic.

REQUESTS FOR PARTICIPATION

To become a Medicaid provider of services, the provider must request a participation agreement by writing:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-5105 or 1-888-829-5373 (in state toll-free), fax – 804-270-7027

PARTICIPATION REQUIREMENTS

Providers approved for participation in the Medicaid Program must perform the following activities as well as any other specified by DMAS:

- Immediately notify the Department of Medical Assistance Services, in writing, of any change in the information which the provider previously submitted to the FIRST HEALTH Services Corporation, Enrollment/Certification Unit. Many forms, checks, and communications are being returned to Medicaid because the Program does not have a current address for the provider. Advise the Medicaid Program in writing of a change of address and an effective date prior to the change.

- Assure freedom of choice to recipients in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the service(s) required and participating in the Medicaid Program at the time the service is performed.

- Assure the recipient's freedom to reject medical care and treatment.

- Comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §§ 2000d through 2000d-4a), which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the ground of race, color, or national origin.

- Provide services, good, and supplies to recipients in full compliance with the requirements of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), which states that no otherwise qualified individual with a disability shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Act requires reasonable accommodations for certain persons with disabilities.

- Provide services and supplies to recipients in the same quality and mode of delivery as provided to the general public.

- Charge DMAS for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges to the general public.

- Accept as payment in full the amount established by DMAS to be reasonable cost or maximum allowable charge. 42 CFR, § 447.15 provides that a State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency. The provider should not attempt to collect from the recipient or the recipient's responsible relative(s) any amount that exceeds the usual Medicaid allowance for the service rendered. For example: If a third party payer reimburses $5.00 out of an $8.00 charge, and Medicaid's allowance is $5.00, the provider may not attempt to collect the $3.00 difference from Medicaid, the recipient, a spouse, or a responsible relative.

- May not bill the recipient for missed or broken appointments.

- Accept assignment of Medicare benefits for eligible Medicaid recipients.

- Use Medicaid Program-designated billing forms for submission of charges.

- Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided. (Refer to the section in this chapter regarding documentation of records.)

  Such records must be retained for a period of not less than five years from the date of service or as provided by applicable state laws, whichever period is longer. If an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved. (Refer to the section in this chapter titled “Documentation of Records.”

- Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities.

- Disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to Medicaid recipients.

- Hold information regarding recipients confidential. A provider shall disclose information in his or her possession only when the information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of the state agency. The state agency shall not disclose medical information to the public.

PARTICIPATION CONDITIONS

All providers enrolled in the Virginia Medicaid Program must adhere to the conditions of participation outlined in their individual provider agreements.

(See "Exhibits" at the end of the chapter for a sample of the form "Physician-Directed Provider Agreement" – DMAS-111.)

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

Section 504 of the Rehabilitation Act of 1973, as amended (29 U. S. C. §794), provides that no disabled individual shall, solely by reason of the disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. As a condition of participation, all Medicaid providers are responsible for making provision for handicapped individuals in their program activities.

As an agent of the federal government in the distribution of funds, DMAS is responsible for monitoring the compliance of individual providers. A compliance notice is printed on the back of checks issued to providers, and, by endorsement, the provider indicates compliance with § 504 of the Rehabilitation Act.

In the event a discrimination complaint is lodged, DMAS is required to provide the Office of Civil Rights (OCR) with any evidence regarding compliance with these requirements.

UTILIZATION OF INSURANCE BENEFITS

The Virginia Medical Assistance Program is a "last pay" program. Benefits available under Medical Assistance shall be reduced to the extent that they are available through other federal, state, or local programs; coverage provided under federal or state law; other insurance; or third-party liability.

Health, hospital, Workers' Compensation, or accident insurance benefits shall be used to the fullest extent in meeting the medical needs of the covered person. Supplementation of available benefits shall be as follows:

- **Title XVIII (Medicare)** - Virginia Medicaid will pay the amount of any deductible or coinsurance for covered health care benefits under Title XVIII of the Social Security Act for all eligible persons covered by Medicare and Medicaid.
- **Workers' Compensation** - No Medicaid Program payments shall be made for a patient covered by Workers' Compensation.
- **Other Health Insurance** - When a recipient has other health insurance (such as CHAMPUS/TRICARE, Blue Cross-Blue Shield, or Medicare), Medicaid requires

that these benefits be used first. Supplementation shall be made by the Medicaid Program when necessary, but the combined total payment from all insurance shall not exceed the amount payable under Medicaid had there been no other insurance.

- **Liability Insurance for Accidental Injuries** - The Department of Medical Assistance Services will seek repayment from any settlements or judgments in favor of Medicaid recipients who receive medical care as the result of the negligence of another. If a recipient is treated as the result of an accident and the Department of Medical Assistance Services is billed for this treatment, Medicaid should be notified promptly so action can be initiated by Medicaid to establish a lien as set forth in § 8.01-66.9, Code of Virginia. In liability cases, providers may choose to bill the third-party carrier or file a lien in lieu of billing Medicaid.

  In the case of an accident in which there is a possibility of third-party liability or if the recipient reports a third-party responsibility (other than those cited on his or her Medical Assistance Identification Card), and whether or not Medicaid is billed by the provider for rendered services related to the accident, the physician is requested to forward the DMAS-1000 to:

  Third-Party Liability Unit
  Department of Medical Assistance Services
  600 East Broad Street, Suite 1300
  Richmond, Virginia 23219

(Form DMAS 161 should be used for ordering the DMAS-1000. See "Exhibits" at the end of this chapter for a sample of the form "Third Party Liability Report" – DMAS-1000, and Chapter IV, for a sample of "Request for Forms" – DMAS 161.)

TERMINATION OF PROVIDER PARTICIPATION

The participation agreement will be time-limited with periodic renewals required. DMAS will request a renewal of the Participation Agreement prior to its expiration.

A participating provider may terminate his or her participation in Medicaid at any time. Thirty (30) days' written notification of voluntary termination should be made to the Director, Department of Medical Assistance Services.

DMAS may terminate a provider from participation upon thirty (30) days' written notification. Such action precludes further payment by DMAS for services provided recipients subsequent to the date specified in the termination notice.

Section 32.1-325(c) of the Code of Virginia mandates that "Any such (Medicaid) agreement or contract shall terminate upon conviction of the provider of a felony."

A provider convicted of a felony in Virginia or in any other of the 50 states must, within 30 days, notify Medicaid of this conviction and relinquish the agreement. Reinstatement will be contingent upon provisions of state law.

RECONSIDERATION OF ADVERSE ACTIONS

The following procedures will be available to all providers when DMAS takes adverse action which includes termination or suspension of the provider agreement.

The reconsideration process will consist of three phases: a written response and reconsideration of the preliminary findings, an informal conference, and a formal evidentiary hearing. The provider will have 30 days to submit information for written reconsideration and will have 15 days' notice to request an informal conference or a formal evidentiary hearing.

An appeal of adverse actions concerning provider reimbursement shall be heard in accordance with the Administrative Process Act (§§ 9-6.14:1 through –6.14:25.) and the *State Plan for Medical Assistance* provided for in § 32.1-325 of the Code of Virginia.

Any legal representative of a provider must be duly licensed to practice law in the Commonwealth of Virginia.

Repayment of Identified Overpayments

Pursuant to § 32.1-325.1 of the Code of Virginia, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When a lump sum cash payment is not made, interest will be added on the declining balance at the statutory rate, pursuant to the § 32.1-313.1 of the Code of Virginia. Interest will not apply pending appeal. Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates to the satisfaction of DMAS a financial hardship warranting extended repayment terms.

MEDICAID PROGRAM INFORMATION

Federal regulations governing program operations require Virginia Medicaid to supply program information to all providers. The current system for distributing this information is keyed to the provider number on the enrollment file, which means that each assigned provider receives program information.

A provider may not wish to receive provider manuals or Medicaid memoranda because he or she has access to the publications as a part of a group practice. To suppress the receipt of this information, the First Health Provider Enrollment Unit requires the provider to complete the Mail Suppression Form and return it to:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-5105 or 1-888-829-5373 (in state toll-free), fax – 804-270-7027

Upon receipt of the completed form, FH-PEU will process it and the provider named on the form will no longer receive publications from DMAS. To resume the mailings, a written request sent to the same address is required.

EXHIBITS

EXHIBITS TABLE OF CONTENTS

DO NOT WRITE IN SHADED AREAS. DO NOT ADD CONDITIONS TO THE AGREEMENT. WE DO NOT ACCEPT AGREEMENTS VIA FAX OR AGREEMENTS ON THERMAL PAPER.

Commonwealth of Virginia
Department of Medical Assistance Services
Medical Assistance Program

Physician-Directed Participation Agreement

If re-enrolling, enter Medicaid Provider Number here→ _____ Check this box if requesting new number→ ☐

Type of provider:

Ambulatory Surgical Center	☐	Federally Qualified Health Center	☐	Rural Health Clinic	☐	Outpatient Clinic	☐
Health Dept. Dental Clinic	☐	FQHC Dental Clinic	☐	RHC Dental Clinic	☐	Hospital Dental Clinic	☐
Mental Health Clinic	☐						

This is to certify:	PAYMENT/CORRESPONDENCE ADDRESS	PHYSICAL ADDRESS (*REQUIRED IF DIFFERENT FROM PAYMENT ADDRESS*)
NAME		
ATTENTION		
ADDR LINE 1		
ADDR LINE 2		
CITY, STATE, ZIP		

on this _____day of _____ , _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.

1. **The applicant has a full-time physician authorized to practice under the laws of the state in which he is licensed and practicing and is not as a matter of state or federal law disqualified from participating in the Program.**
2. **The applicant shall be free to accept or refuse a recipient in accordance with the principles of the standards of ethics of the professional association of his area of practice. Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. No handicapped individual shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in (Section 504 of the Rehabilitation Act of I973 29 USC.794) VMAP.**
3. **Services rendered must be those provided. Payment is to be made only to those providers who actually render the services.**
4. **The applicant agrees to keep such records as VMAP determines necessary. The applicant will furnish VMAP on request information regarding payments claimed for providing services under the State Plan. Access to records and facilities by authorized VMAP representatives and the Attorney General of Virginia or his authorized representatives, and federal personnel will be permitted upon reasonable request.**
5. **The applicant agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable concept and agrees that all requests for payment will comply in all respects with the policies of VMAP for the submission of claims.**
6. **Payment made by VMAP constitutes full payment except for patient pay amounts determined by VMAP, and the applicant agrees not to submit additional charges to the recipient for services covered under VMAP. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a medical assistance recipient for any service provided under medical assistance is expressly prohibited.**
7. **The applicant agrees to pursue all other available third party payment sources prior to submitting a claim to VMAP.**
8. **Payment by VMAP at its established rates for the services involved shall constitute full payment for the services rendered. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by VMAP, the provider will reimburse VMAP upon demand.**
9. **The applicant agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of VMAP as from time to time amended.**
10. **This agreement may be terminated at will on thirty days' written notice by either party or by VMAP when the provider is no longer eligible to participate in the Program.**
11. **All disputes regarding provider reimbursement and/or termination of this agreement by VMAP for any reason shall be resolved through administrative proceedings conducted at the office of VMAP in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.**

12. **This agreement shall commence on _____ and terminate on _____.**

For Provider of Services:

For FIRST HEALTH's use *only*

Director, Division of Program Operations Date

Original Signature of Provider **Date**

Signature of Administrator (if applicable)

_____City OR _____County of _____

IRS Identification Number **(Area Code) Telephone Number**

Board of Medicine License Number **UPIN**

Medicare Carrier and Vendor Number

IRS Name (required)

mail **one** completed **original** agreement to: **FIRST HEALTH - VMAP-Provider Enrollment Unit 4461 Cox Rd. Suite 102 Glen Allen, VA 23060-3331**

VIRGINIA

Department of Medical Assistance Services
600 East Broad Street
Suite 1300
Richmond, Virginia
23219

THIRD PARTY LIABILITY INFORMATION REPORT

(FOR MEDICAID PROVIDERS' USE)

This form MUST be submitted to the Department of Medical Assistance Services within 30 days after a service is rendered to a Virginia Medicaid recipient for the treatment of accident related injuries. Federal Regulations (42CFR - 433.138) require the Department of Medical Assistance Services to exert positive efforts toward locating liable third parties and to diligently seek refunds of applicable liability payments. Please complete this form to the best of your knowledge to assist us in this effort. Statutory authority is provided for full recovery of funds from liable third parties in Section 8.01-66.9 of the Code of Virginia.

PLEASE TYPE OR PRINT

NAME OF RECIPIENT: _____
(LAST) (FIRST) (MI)

RECIPIENT'S ELIGIBILITY NO. _____ DATE OF INJURY _____

TYPE OF ACCIDENT _____ DATE YOUR SERVICE BEGAN _____
(WORK, AUTO, HOME, GUNSHOT, ETC.)

NAME OF ATTORNEY _____

ADDRESS _____

(IF RECIPIENT HAS AN ATTORNEY, THE FOLLOWING INFORMATION IS NOT NEEDED.)

NAME OF INSURANCE COMPANY _____

ADDRESS _____

NAME OF INSURED PERSON _____

POLICY NO. _____ CLAIM NO. _____

COMMENTS _____

_____

_____

DIAGNOSIS _____ NAME OF PROVIDER _____

IS TREATMENT COMPLETED _____ YES _____ NO

DATE _____ BY _____

Providers will not be involved in litigation or collection attempts by the Department of Medical Assistance Services nor will reimbursement to the provider be withheld as a result of submitting this form.

PLEASE MAIL TO:

THIRD PARTY LIABILITY/CASUALTY
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
600 E. BROAD STREET, SUITE 1300
RICHMOND, VIRGINIA 23219

DMAS - 1000 R9/87

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

MAILING SUSPENSION REQUEST

Medicaid Provider Number: _____

Provider Name: _____

I do not wish to receive Medicaid memos, forms or manual updates under the Medicaid provider number given above because the information is available to me under Medicaid provider number

Provider Signature: _____

Date: _____

Please return this completed form to:

First Health Provider Enrollment Unit
P.O. Box 26803
Richmond, VA 23261-6803